Michigan Mental Health Commission
established by Governor Jennifer Granholm's Executive Order 2003–24

MENTAL HEALTH COMMISSION MEETING SUMMARY

August 17, 2004
Holiday Inn West
Lansing, Michigan

Commissioners Present

Patrick Babcock, Co-chair; William Allen, Elizabeth Bauer, Beverly Blaney, Thomas Carli, Patricia Caruso, Nick Ciaramitaro, Bill Gill, Joan Jackson Johnson, Gilda Jacobs, Alexis Kaczynski, Sander Levin, Kathryn Lynnes, Milton Mack, Samir Mashni, Andy Meisner, Janet Olszewski, Donna Orrin, Jeff Patton, Brian Peppler, Michele Reid, Mark Reinstein, Roberta Sanders, David Sprey, Sara Stech, Maxine Thome, Thomas Watkins.

Welcome and Overview of Today's Agenda

The meeting was convened at 8:40 am. Patrick Babcock called the meeting to order and reviewed the agenda for the day. Mr. Babcock outlined the goals for the meeting. He said the commission should work to come to an agreement about what population the system should serve and what array of services should be available to those served.

Mr. Babcock reminded the commissioners of the time frame for completing their work. He recommended that the commission commit itself to meeting the timeline of the Executive Order, providing preliminary recommendations to the governor by September 30 and the final report by October 25. He suggested that this may require one or two additional meetings of the commission.

Approval of July 26 Meeting Summary

Updates

Commissioner Donna Orrin advocated for an additional presentation on the recovery model by LeRoy Spaniol of the Center for Psychiatric Rehabilitation at Boston University. A PowerPoint presentation on the recovery model was available to commissioners in their meeting packets.

It was announced that the state surgeon general would like to speak to the commission about her initiatives that coincide with the commission's work; this briefing will be scheduled.

Public Comment on the Commission's Proposed Key Issues and Options

Lynn Anderson – Spoke about the historical poor conditions for persons with a mental illness. Current conditions are improved, but we still haven't met the needs of the mentally ill. We don't want to return to the old hospital system-we need to provide additional community supports so that people can live in the community. Asks for compassion and hope.

Steve Ruskin – Consumer from Oakland County and a board member of Oakland County CMH. Spoke about need for peer-supported services, self-employment and consumer education. Need to empower consumers and involve them in service delivery. Supports person-centered planning and self-determination-often results in cost savings because consumers only choose services and supports that are most important to their personal needs. Need to provide consumers with choices and flexibility. Need to expand supported education programs through peer-supported services.

Gene Cowdery – Consumer from Gratiot County. Supports the existing CMH system. Important that CMH services continue to be available. CMH services benefit consumers and are needed. Spoke about her experience using clubhouse services

Hubert Huebl, M.D. – Representing the National Alliance for the Mentally Ill (NAMI) of Michigan as president. Spoke about: 1) Accountability-should be some blending of private sector and public sector mental health services to prevent tragic outcomes for some consumers, suggests that DCH have some role in overseeing both the private and public sectors, 2) Co-occurring Disorders-often are addressed separately-need to address together, gave history of a person with both a mental illness and a substance abuse disorder, 3) Detroit-Wayne County CMH-need to audit the funding to the agency and the managed care provider networks.

Diana Goodrich – Consumer served by Clinton-Eaton-Ingham CMH. Receives day program services in St. Johns, MI. Spoke about her difficulties in getting medical and dental care prior to her involvement with CMH. Services have improved her life. She also receives transportation services from CMH. She now volunteers and is pleased that she is able to give back to her community. CMH provides her with the information she needs to live in the community.

Jonathon Henry, M.D. – Psychiatrist and Medical Director at Clinton-Eaton-Ingham CMH. Also a member of the Michigan Psychiatric Society. Provided members of the Commission with a written statement. Spoke about the need to re-establish the position of medical services director (should be a psychiatrist) at DCH with adequate staff to provide medical leadership to the CMH system-42 other states have medical directors in the public mental health system. Spoke about the value of evidence-based practice and the need to address areas where evidence-based practices do not yet exist. DCH medical director should provide leadership for integration of best practices within the CMH system. Medical director should also serve as liaison to DCH committees and advisory bodies (e.g. Mental Health Advisory Committee, Pharmacy Utilization Committee, etc.). Identified several other roles for the medical director.

Denice Virgo – Recipient rights staff person working in Southeast Partnership PIHP (Lenawee, Livingston, Monroe, Washtenaw Counties). Also family member of consumers (sister and daughter). Spoke about proposed recommendation to have CMH recipient rights staff be restructured to be part of the state Office of Recipient Rights (ORR). Acknowledges that there are weaknesses in the existing CMH recipient rights system, but supports that the system remain at the local CMH level and that weaknesses be addressed. Moving the system to the state ORR would reduce the prevention aspect of the community recipient rights system and unanticipated problems would result.

Chris Valentine – Family member of consumer from Huron County. Commented on Commission work group proposed recommendations: 1) Array of Services-need to list specific services and time frames for providing service, 2) Structure-need to reorganize to 18 PIHPs, but maintain local CMH structure, 3) General-recommendations need to be specific including time frames for completion and who is responsible, also that recommendations need to be provided to the public with time allowed for comment before being finalized.

Kathy Reynolds – Executive Director of Washtenaw County CMH. Presented the Michigan Association of Community Mental Health Boards position on the recipient rights system. Doesn't believe that the public comments regarding the recipient rights system accurately reflect the views of all consumers. Ask the Commission to consider the question: Should the system be changed based on the comments of less than 10% of the consumer community? Spoke about the benefits of the existing recipient rights system including its protections, appeals process, ORR director being part of the CMH administrative/management team, etc. These benefits could be reduced or eliminated if the system went from a community structure to a state ORR structure. Proposed that the existing system be modified to address consumer issues, but that the existing local structure and organization be maintained.

Elmer Cerano – Executive Director of Michigan Protection and Advocacy agency. Took exception to some of the other comments regarding the recipient rights system staying at the local level. Said that the recipient rights system is broken and can't be fixed by "tweaking" the existing system. Also spoke about how the current system of separate CMHs should be eliminated and replaced by the 18 PIHPs-nothing has changed from the old system of individual CMHs prior to the creation of the 18 PIHPs. Also cautioned that the state not move to a Medicaid block grant-has money up front, but would prevent any future growth. Spoke about the problem regarding children who lose Medicaid coverage when they enter a hospital and then experience difficulty getting back on Medicaid later. Also spoke about proposed legislation to force treatment on some persons with a mental illness and the possible dangers in this approach.

Jana Perez – Consumer from Gratiot County. Spoke about how CMH services help people live better lives. CMH provides job-training services to help people find jobs-puts people in the work force. CMH helped her to break the cycle of hospitalization followed by discharge followed by more hospitalization. Said it is important to serve people as soon as possible, before they become seriously ill.

Vicki Suder – Consumer from Oakland County. Spoke about the benefits of CMH services and how they help people recover from a mental illness. CMH services empower consumers. Identified several services that CMH provides that help people to live in the community and receive the necessary supports. Asked the Commission to please remember the benefits of the CMH system.

Ruth Zweifler – Representing the Student Advocacy Center of Michigan/All Kids in School. Spoke about the negative aspect of the violence zero-tolerance policy in schools and its effect on vulnerable children including those who have emotional/behavioral disorders. Gave several examples of children being expelled from school due to poor

decision-making skills or behaviors that they can't control. Asked that the Commission consider this population.

Mary Simon – Representing the Recipient Rights Officer Association of Michigan. Works as a rights officer at Sanilac County CMH. Supports the position that the recipient rights system needs to be fair and unbiased, but does not support moving rights officers from the local level to a state ORR. Asked that more information be gathered before moving to reorganize the recipient rights system. Need to get input from local rights officers before making any recommendations.

Peggy Hendrickson – Prevention services director from AuSable Valley CMH. Spoke about the importance of prevention services for children and adolescents. Prevention is science-based. School-based services are important prevention services. Need to provide funding so that every CMH has adequate prevention services. Prevention services help to reduce costs and enhance the existing CMH system.

Dan Moran – Consumer from Oakland County. Also works for Oakland County CMH. Spoke about the self-advocacy network of Michigan. Need more consumer involvement in the CMH system. Also asked that the Commission seek input from consumers in making its recommendations. Supports the need for advocacy groups to speak for consumers who can't speak for themselves.

V. P. Veluswamy, M.D. – Retired psychiatrist with many years of experience working in the CMH system. Recommended changes in the medication distribution process in CMH system-rely too much on sample medications provided by the drug companies. Also need to provide adequate outpatient services and support services to prevent people from developing a chronic mental health condition. Spoke about mental health services to people in jail-often people refuse services-need to have court orders to treat people. Also recommends that forensic exams be completed more timely-people are staying in jail too long because they are waiting for a forensic exam. Spoke about the importance of the medical director's role at a CMH and how the medical director should report to the CMH board.

A. N. Veluswamy, M.D. – Retired psychiatrist. Spoke about the need to provide consumers with rehabilitation services very early in their treatment. Spoke about the services provided by Rose Hill residential treatment facility.

Connie Bain – Recipient rights officer at Sparrow Health Systems. Also serves on state recipient rights appeals committee. Spoke about the important role played by the recipient rights officer at a hospital. Said that mental health consumers are being discharged from hospitals too soon because of private insurance coverage that limits hospital stays-this doesn't happen for medical patients. Early discharge results in people being re-hospitalized and having more difficulty than before.

Paul Cloutier – Representing Michigan Family Independence Agency-Native American Affairs. Spoke about the importance of CMH collaboration with Native American tribes at the local level. Recommended that a tribe member be represented on each CMH board where a tribe is located.

Mary Seffernick – Parent of an adopted son with a serious emotional disturbance from Jackson County. Spoke with great emotion about the many problems the family experienced in accessing services for their son and how the system failed their son. Told many times that their son was not sick enough to qualify for the services that they felt he needed. Received good services at Fieldstone Hospital, but wasn't there long enough. Placed in a residential treatment program-served a jail term for stealing a car from that program. Spoke about the services from Lifeways CMH that didn't meet her son's needs-CMH said he was not suitable for treatment even though he was suicidal. Her son ultimately committed suicide. Wanted the Commission to know how her son's life could have been different if he had received the appropriate mental health services when he most needed them.

Linda Braden – Consumer from Oakland County receiving services from Community Network Services. She has been hospitalized many times and praises the services that she receives from Community Network Services through Oakland County CMH-services in the community help to keep people out of the hospital. Asks that funding be provided to continue and expand these services.

Karen Edwards – Consumer from Oakland County receiving services from Oakland County CMH. Performed a role-play showing how her mental illness influenced her life before she started receiving services and how her life has improved due to the CMH services that she now receives. Prior to receiving services, she was often suicidal. Praised services of the clubhouse program in Oakland County. Said she is "somebody" and wants to be treated as "somebody".

David LaLumia – Executive Director of the Michigan Association of Community Mental Health Boards. Spoke about the MACMHB support for addressing anti-stigma efforts and for mental health insurance parity. Also spoke about the need for local systems to continue their partnership arrangements to support children and the need to support the existing recipient rights system. Questioned how the proposed recommendation to eliminate the current 46 CMHs will result in benefits. Said that fundamental and substantial changes have occurred under the current structure of 18 PIHPs for Medicaid services. MACMHB supports strengthening the mental health administration of DCH-the shrinking mental health budget is the most serious problem affecting the mental health system.

Gary Wyatt – Consumer representing the Depression and Bipolar Support Alliance of Metro Detroit. Spoke about the need for affordable medications and adequate support services for consumers, decreased case loads for case managers and other mental health professionals, improved services to children and families, and mental health insurance parity. Said that the community system wasn't supported enough when it changed from the former hospital-based system, need to support psychiatric intervention, access to therapy and support services to improve the community system. Spoke very passionately about his life and his friends who also have a mental illness. Asked that the Commission help the staff in the mental health system to do their job and also involve consumers in their deliberations.

Steve Hill – Consumer from Oakland County. Asked that the Commission consider that you shouldn't fund something that doesn't work, but that something can't work if it isn't fully funded. Also need to provide information to consumers so that they can make an informed decision regarding mental health services. Said that accountability is a central issue that needs to be addressed-judge CMHs on their performance.

Goals, Issues, and Rationale: Review and Consensus

Pat Babcock described the process for reviewing the goals, issue statements, and rationale for the afternoon. The commission was to review the preliminary draft from the Project Management Team to reach consensus on each goal statement, issue statement, and rationale.

Goal 1: The public knows that mental illness is treatable, recovery is possible, and many people with mental illness lead productive lives.

After discussing the goal statement, commissioners agreed that the word "many" should be removed from the goal. It will read: "The public knows that mental illness is treatable, recovery is possible, and people with mental illness lead productive lives."

With regard to the issue statement for the goal, one commissioner noted she felt that a statement should be included that providers and families in the community, as well as the individual in treatment, need to believe in the individual for recovery to work. She suggested that HOPE scales (a recovery-oriented treatment tool) could be used for outcome measurements.

The commissioners then discussed the accuracy of the phrase "almost total reliance on Medicaid." Most agreed that the phrase would be improved and more accurate if it read "significant reliance." A recommendation was made to include a footnote to the issue statement for the phrase to provide clarification of the word "significant."

Another commissioner recommended that language should be added to the issue statement about needing investments from the private sector along with investments from the public sector.

Specific recommendations were also made for modifying the rationale for goal 1. One commissioner suggested that language be added to note the need for widespread recognition of medication and multidisciplinary treatment advances and the impact of those treatments. In other words, success stories need to be more prevalent in the media and other information outlets.

Another commissioner was concerned that there is too much emphasis on the financial cost of mental illness and not enough discussion of the human cost, i.e., the longer people go without treatment, the less likely they are to reach their full potential. Perhaps this could be addressed with two separate paragraphs: one on the financial costs and the other on the human costs of mental illness. Other commissioners agreed that it is an important point to make, and they discussed whether the information belonged in the rationale, the issue statement, or both.

Process Discussion

After discussing goal 1 and the related issue statement and rationale, the commission discussed the process by which they are reviewing the draft report, recognizing that it is a lengthier process than they had anticipated. Some recommended having the draft sent out by e-mail to the commissioners for their individual comments then sent back to PSC to coalesce. Others suggested that the commission continue to review the entire document as a full group to assure decisions are not made without consensus. Based on this suggestion, the commissioners agreed that, at this meeting, they should first review the goal statements, one by one, followed by the issue statements if time allowed. The rationale, they agreed, may need to be discussed after the options are fleshed out.

Goal 2: The mental health of all children and adults is promoted and their mental health needs are met at the earliest opportunity.

One commissioner suggested and consensus was reached that "families" should be included in the goal statement so it would read: "The mental health of all children, their families, and adults…."

Another commissioner expressed her dislike of the word "promoted" because she believes it is not strong enough and may be too "touchy feely." Commissioners agreed to remove that phrase from the goal statement.

Commissioners then discussed the phrase "earliest opportunity." There was some concern that the phrase leaves too much room for interpretation. The group agreed on the phase "needs are appropriately met."

The goal statement now reads: "The mental health needs of all children, their families, and adults are appropriately met."

One commissioner noted that the use of the word "all" forces the commission to discuss the issue of whether they are promoting a public mental health system that serves *all* Michigan residents. Discussion of this issue centered around the idea that the report of the commission will encourage public and private partnerships, which makes the goal statement appropriate, as well as the idea that the commissioners do not want to aspire to anything less than appropriate mental health treatment for all of Michigan's citizens. It was agreed to leave the word in the goal statement, but to qualify it in the issue and rationale statements.

Goal 3: No one ends up in the juvenile and criminal justice systems because of inadequate mental health care.

The commissioners discussed alternatives to the phrase "ends up" and agreed to use the term "enters" instead.

A commissioner suggested adding "inadequate assessment" to "inadequate mental health care" but others stated that it would make the phrase too wordy and that assessment is part of mental health care. Inadequate assessment can be addressed specifically in the issue statement.

Goal 4: A full array of high quality mental health treatment, services, and supports is accessible in communities to improve the quality of life for individuals with mental illness and their families.

A commissioner suggested that "full continuum of care" be added after "supports" and that "long-term residential care" also be mentioned specifically in the goal statement. Other commissioners noted that "continuum" is synonymous with "array," which is already used in the goal statement. They also argued for keeping the statement concise by incorporating the new language into the issue and rationale statements rather than the goal statement.

Another commissioner expressed concern that the words "in communities" might be read to preclude secure facilities. The commission agreed to remove the phrase "in communities" from the goal statement, but to use the issue and rationale statements to emphasize the importance of treatment in communities when possible.

Goal 5: Michigan's mental health system is structured and funded to deliver high-quality care effectively and efficiently by accountable providers.

The commissioners briefly discussed the reach of the system, noting that the issue statement refers directly to the "public" mental health system. A commissioner pointed out that if a private entity is on a subcontract, they are partially using public dollars. The commission agreed that the use of the word "accountable" is a good way to capture the reach of the system.

Goal 6: Recovery is supported by access to integrated mental and physical health care, housing and employment supports, and education to assure that all people have the opportunity to reach their full potential as contributing members of society.

When discussing this goal statement, commissioners questioned whether an array of services supporting recovery including housing, employment, and education belongs in the same goal statement with the integration of mental and physical health care. Some stated that the supports for recovery are covered by the array of services stipulated in goal 4, or that the concept of recovery could be added to goal 2, while the integration of mental and physical health care could be kept as goal 6.

Another commissioner noted that the goal statement works as is because it is stating that the mental health system cannot stand by itself.

There was another concern that the statement is too narrow in that it suggested that all recovery is somehow supported by the state making it difficult to bring the private sector into the statement.

The commission agreed to change the statement to read: "Recovery is supported by access to integrated mental and physical health care, housing, employment opportunities, and education to ensure that all people have the opportunity to reach their full potential as contributing members of society."

Goal 7: New

A commissioner noted that in the six goals all of the value statements are covered except the idea of a consumer-driven system. He suggested adding a seventh goal, to which all the commissioners agreed: "Consumers and families are actively involved in service planning, delivery, and monitoring at all levels of the public mental health system."

Defining the Mental Health System: Public vs. Private

The following is a summary of the comments made as the commission discussed how it will define, and therefore make recommendations related to, Michigan's mental health system.

It was noted as a starting point that the charge to the commission in the Executive Order (EO) is to address the public system, but the governor also listed parity as an issue for the commission to address. It was suggested that one of the reasons for the inclusion of parity in the EO is that there is not enough support from the private system to cover its share of people with serious mental illness and the services they need. The governor asked the Mental Health Commission to propose pragmatic recommendations, recognizing the interface with the private system.

While commissioners agreed that the focus should be on pragmatic suggestions, an underlying issue they felt must be addressed is stigma because it underlies every problem raised in the issue statements. A commissioner stated that in order to address stigma, the private sector must also be included in the recommendations.

Another commissioner noted that although they removed the word "promoted" from goal 2, if you look at the issue from a public health standpoint, there are things that can be done to promote the mental health system to people who don't know where to turn for help.

Another way in which the private sector can be brought to bear in the commission's report is to recommend that the state increase efforts to bring research here through incentives for using the life sciences corridor. The state can provide economic development incentives.

The commissioners ultimately agreed to discuss the private sector in the report only as it relates to the public sector. They agreed that there are things outside of their scope in the private sector, but issues such as parity could be addressed because people come into the public sector from the private sector who lack the insurance resources needed for mental health care.

Who Should Be Served by the Michigan Mental Health System?

When discussing the issue of who should be served by Michigan's mental health system, one commissioner offered the answer: "Those people the private sector doesn't serve. We pick up the pieces."

Most commissioners agreed with this sentiment, but one stated that the commission cannot lose sight of people who aren't served by either system.

Commissioners noted that screening and early intervention are important, including the need to encourage private practitioners to conduct screenings and identify mental illness early. This begged the question as to what role the state can play in improving assessment and referral from physical health care providers. They noted that *encouragement* is one thing; *requirement* is different. You have to have the power to require something or to regulate it. This will require further information about the possible functions of the state in this capacity.

Commissioners noted that the system is currently serving a lot of people, but it is not serving everyone in need. The system is serving people with the most serious mental illnesses, and with the recent adult benefits waiver, it is serving more adults with moderate illnesses. However, the system is not funded to serve all of those in need. Commissioners expressed the sentiment that all people in need should be served, but there must be a plan in order to make that happen.

One commissioner noted that if we look at reality, people with and without Medicaid are being served, and the Mental Health Code does not preclude us from seeing those not seriously mentally ill, but we have to serve those with serious mental illness first. She went on to suggest that if care must be rationed, there has to be a rationale for the way it is done and guidance for this should come from the state level.

Another commissioner noted that the system is serving people who are really the obligation of other sectors that didn't do their job. The governor should get other sectors to fulfill their statutory responsibilities.

Another suggested that although the commission wants to serve everyone who is uninsured, funding is all being spent on those who are seriously mentally ill. The commission will need to identify funds to serve the uninsured. This will require huge upfront costs, but in the long run it will cost less.

Commissioners noted that spending on crisis management is a vicious cycle. Psychiatric crises have to be responded to, so that is where the majority of funding is spent, leaving too little for prevention, which could help ameliorate the need for crisis spending in the long run.

Mark Reinstein stated that he and Tom Carli have identified a number of potential strategies for increasing funding and services for people with mild and moderate mental illness. Reinstein and Carli, with help from Patrick Barrie, will draft a proposal listing these options to present to the commission at the next meeting.

Patrick Barrie has written a paper outlining financing options for the mental health system. It was distributed to the commission and should inform the debate as to whether the commission will recommend that the state apply for a Section 1115 waiver.

Adjournment

The next meeting will include discussion on the structure and financing of the system. Pat Babcock said that the commission would probably hold an additional meeting in September. The commissioners will be notified once a meeting is scheduled.